MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY

DURABLE MEDICAL EQUIPMENT AND SUPPLIES (Rev., Jul 99)

MOTORIZED WHEELCHAIRS

PATIENT NAME, ADDRESS, TELEPHONE NUMBER, DATE OF BIRTH	PHYSICIAN NAME, ADDRESS, TELEPHONE NUMBER
MEDICAID I.D. NUMBER	MEDICAID PROVIDER NUMBER:
DIAGNOSIS:	HEIGHT: WEIGHT:
PROGNOSIS:	EST. LENGTH OF NEED (# OF MONTHS): 1-99 (99 = LIFETIME)

1. Does this recipient currently own a wheelchair? If no, go to question 2. Y / N

   1a. Date of purchase
   1b. Type of wheelchair
   1c. Condition
   1d. Original Supplier of current wheelchair
   1e. Repairs/modifications within last 6 months

2. Current residence: (circle the appropriate) Home; Nursing Home; Hospital Rehab Unit; Institution; Group Home; Other _____

3. Does recipient require and use a wheelchair to move around in their residence? Y / N

4. How many hours per day does the recipient usually spend in the wheelchair? (1-24hrs) (Round up to the next hour)

5. Is the recipient unable to operate any type of manual wheelchair? Y / N

6. Does the recipient have the physical and mental ability to operate the requested wheelchair in a safe manner? Y / N

7. Can the recipient ambulate? If yes, How and how far? Y / N

8. Will recipient's home and transportation accommodate this requested wheelchair? Y / N

9. Narrative description of **ALL** items, accessories, sizes and options to be included on this wheelchair: (If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document.)

Y / N ADDITIONAL ATTACHMENTS ARE INCLUDED

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

MONTANA
Department of Public Health & Human Services